Recovery, Psychosis and Psychiatry: research is better than rhetoric

Mike Slade, Mark Hayward

Dr Mike Slade
Clinical Senior Lecturer
Health Service and Population Research Department (Box P029), Institute of Psychiatry, King's College London, London SE5 8AF

Dr Mark Hayward
Department of Psychology, University of Surrey, Guildford GU2 7XH

Correspondence to: M Slade
m.slade@iop.kcl.ac.uk

Recovery has been defined as '*a personal process of overcoming the negative impact of diagnosed mental illness / distress despite its continued presence*' (1, p. 2). The approach has received many endorsements. In the UK, policy states that "*Services of the future will talk as much about recovery as they do about symptoms and illness*" (2, p. 24), and professional groups such as psychiatrists (3) and nurses (4) have embraced the rhetoric. Internationally, the approach has been formally adopted in New Zealand (5), the Republic of Ireland (6) and the United States (7), among others. Guidance is being disseminated (1) and editorials written (8). Recovery is in vogue.

What are the defining characteristics of a recovery-focussed mental health service? Recovery is understood to mean something different to either sustained remission or cure – it is a way of '*…living a satisfying, hopeful, and contributing life even with the limitations caused by illness.* (9, p.527). Goals are user-defined and therefore individual and sometimes ethically challenging for staff to work with. Staff have an optimistic and hope-inducing view about the ability of people to find meaning in their experiences – to generate a story or narrative about themselves which leads to a future beyond (though possibly including) mental illness. Language is different, because staff recognise the power of language to shape belief, and do not want to limit change by imposing an explanatory illness model when other models may be more helpful to the individual.

The policy and practice implications of recovery-focussed service have been explored elsewhere (10-13). At its simplest, this will mean clinicians basing decisions less on professionally-defined goals and more on listening to *and acting on* the service user's wishes.

If recovery-focussed mental health services differ from traditional services, what has been the response to this call to change? Several responses can be identified. Some researchers have insisted on symptomatological and functional improvement (rather than patient-defined criteria) as the sole indicator of recovery (14, 15). Others commentators express the view that the term 'recovery' is vacuous – "*a redefinition of the term 'recovery' in order to give hope is to build hope on illusion*" (16, p. 48). Services have appropriated the term without meaningfully changing their function, *e.g.* re-labelling rehabilitation services as 'Recovery and Rehabilitation Services'. These responses are all consistent with an aim of maintaining the *status quo*. They may be the most appropriate responses, but the paucity of evidence means that it is currently impossible to have an informed debate.

Empirical research is needed. We therefore propose a research programme to identify the costs and benefits of developing recovery-focussed mental health services.

Recovery research needs to combine methodological rigour with not disadvantaging recovery-focussed approaches by evaluating them using methods and outcome criteria which are biased towards traditional working practices. We identify three strands to this research programme: identification and prevalence; outcome measures and evaluation methodologies; and interventions and cost-effectiveness

First, the **active ingredients** of recovery-focussed mental health services need to be established. As well as working practices, the ingredients will include staff attitudes, values and beliefs. This represents a change from the current modernist approach to describing services (*i.e.* they are fully characterised by what they do), in recognising that mental health services involve people, both using them and working in them, so *how* staff work also matters (17).

Once identified, the active ingredients will inform the development of **fidelity scales**, which assess adherence by the service to the active ingredients required for a mental health service to be recovery-focussed. This approach to ensuring treatment fidelity is a standard approach to identifying whether a service model is actually implemented (18), a necessary element of evaluation (19). These fidelity scales can then be used to establish national baseline **prevalence estimates** of the extent to which services are recovery-focussed.

Second, there is a need to develop **recovery outcome measures**. Some measures have already been developed, mainly in the United States (20, 21) and Australia (22). Cultural validity will be an important psychometric property to establish when they are used in other countries. This will allow **methodological developments** which incorporate utility (i.e. individual preferences) into evaluations. For example, instead of using the same predefined primary outcome measure for all participants in a clinical trial, each participant could choose their own primary outcome measure from a selection of standardised outcome measures.

Similarly, recovery-focussed evaluations are likely to include both qualitative and quantitative methodologies (23), and the use of established user-led methods such as User-Focussed Monitoring (24) or Strategies for Living (25). The development of new approaches to evaluation will be particularly important when evaluating existing interventions involving coercion and compulsion. For

example, they will allow the empirical investigation of whether assertive outreach services promote recovery, rather than (as currently investigated (26, 27)) whether they reduce symptoms and hospitalisation rates.

Finally, there is a need to develop and evaluate **interventions to promote recovery-focussed working**. For example, increased visibility of recovered service users in teams may combats the clinician's illusion that no-one gets better (28). Training programmes may change the language used, which in turn shapes beliefs and actions (29). This will allow the development of **demonstration sites**, with evaluation using innovative methodologies which incorporate both traditional and recovery outcome measures. Two key questions for these demonstration sites will be whether recovery-focussed services actually promote recovery, and whether recovery-focussed services also lead to improvement in professionally-defined domains of outcome. These questions are important, because high-quality decision-making by service users, clinicians and commissioners about interventions and service models is only possible when the costs as well as the benefits are known. For example, if all that is known is that an intervention reduces symptoms, it can be recommended. If it is known that an intervention reduces symptoms and fosters dependency and loss of hope, a more informed debate is possible.

There are three possible futures for recovery in psychosis, First, the term 'recovery' and associated values and working practices fail to impact on services, and slowly disappear. Second, recovery values become embedded in clinical practice, but the term becomes slowly forgotten – similar to the 'social role valorisation' movement in learning disability services. Third, recovery becomes the dominant model and leads to fundamental scientifically well documented changes in mental health practice, on a scale similar to the impact of re-labelling dementia as Alzheimer's Disease. What is best for people experiencing psychosis should decide the future.

References

1 NIMHE. *Emerging Best Practices in Mental Health Recovery*. London: National Institute for Mental Health in England, 2004.

2 Department of Health. *The Journey to Recovery*. London: HMSO, 2001.

3 Royal College of Psychiatrists. *Rehabilitation and recovery now*. London: RCP, 2004.

4 Department of Health. *From values to action: The Chief Nursing Officer's review of mental health nursing*. London: HMSO, 2006.

5 Mental Health Commission. *Blueprint for Mental Health Services in New Zealand*. Wellington: Mental Health Commission, 1998.

6 Mental Health Commission. *A Vision for a Recovery Model in Irish Mental Health Services*. MHC: Dublin, 2005.

7 New Freedom Commission on Mental Health. *Achieving the Promise: Transforming Mental Health Care in America*. Rockville, MD: U.S. Department of Health and Human Services, 2005.

8 Lester H, Gask L. Delivering medical care for patients with serious mental illness or promoting a collaborative model of recovery. *Br J Psychiatr* 2006;**188**:401-2.

9 Anthony WA. Recovery from mental illness: The guiding vision of the mental health service system in the 1990's. *Psychosocial Rehabilitation Journal* 1993;**16**:11-23.

10 Compagni A, Adams N, Daniels A. *International Pathways to Mental Health System Transformation: Strategies and Challenges*. California: California Institute for Mental Health, 2006.

11 Carling PJ, Allott P. *Pathways to Recovery Paper 1. Core Vision and Values for a Modern Mental Health System*. London: Care Service Improvement Partnership, 2006.

12 Roberts G, Wolfson P. The rediscovery of recovery: open to all. *Advances in Psychiatric Treatment* 2004;**10**:37-49.

13 Davidson L, O'Connell M, Tondora J, et al. The Top Ten Concerns About Recovery Encountered in Mental Health System Transformation. *Psychiatric Services*, 2006;**57**:640-5.

14 Liberman R, Kopelowicz A. Recovery from schizophrenia: a concept in search of research. *Psych Serv* 2005;**56**:735-42.

15 Harrison G, Hopper K, Craig T, et al. recovery from psychotic illness: a 15- and 25-year international follow-up study. *British Journal of Psychiatry* 2001;**178**:506-17.

16 Oyebode F. Invited Commentary on: The rediscovery of recovery. *Advances in Psychiatric Treatment* 2004;**10**:48-9.

17 Bracken P, Thomas P. Postpsychiatry: a new direction for mental health. *BMJ* 2001;**322**:724-7.

18 Teague GB, Bond GR, Drake RE. Program fidelity in assertive community treatment: development and use of a measure. *American Journal of Orthopsychiatry* 1998;**68**:216-32.

19 Campbell J, Fitzpatrick R, Haines A et al. Framework for design and evaluation of complex interventions to improve health. *BMJ* 2000;**321**:694-6.

20 Campbell-Orde T, Chamberlin J, Carpenter J, et al. *Measuring the Promise: A Compendium of Recovery Measures, Volume II*. Cambridge, MA: Human Services Research Institute, 2005.

21 Wowra SA, McCarter R. Validation of the Empowerment Scale With an Outpatient Mental Health Population. *Psychiatric Services* 1999;**50**:959-61.

22 Andresen R, Caputi P, Oades L. Stages of recovery instrument: development of a measure of recovery from serious mental illness. *Australian and New Zealand Journal of Psychiatry* 2006;**40**:972-80.

23 Slade M, Priebe S (eds). *Choosing methods in mental health research*. Hove: Routledge, 2006.

24 Rose D, Ford R, Lindley P, Gawith L. *In Our Experience: User-Focussed Monitoring of Mental Health Services*. London: Sainsbury Centre for Mental Health, 1998.

25 Mental Health Foundation. *Strategies for Living*. London: Mental Health Foundation, 2000.

26 Sytema S, Wunderink L, Bloemers W, Roorda L, Wiersma D Assertive community treatment in the Netherlands: a randomised controlled trial, *Acta Psychiatrica Scandinavica*, in press.

27 Fakhoury WKH, Priebe S, PLAO Study Group. An unholy alliance: substance abuse and social exclusion among assertive outreach patients, *Acta Psychiatrica Scandinavica* 2006;**114**:124–31.

28 Hayward M, West S, Green M, et al. Service innovations: service user involvement in training. *Psychiatr Bull* 2005;**29**:428-30.

29 Houghton P, Shaw B, Hayward M, et al. Psychosis Revisited: taking a collaborative look at psychosis. *Mental Health Practice* 2006;**9**:40-3.